SECTION M.
SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. Ulcers (due to any cause) (7-day look back) (*SB-MDS Item 31*)

Intent: To record the number of ulcers, of any type at each ulcer stage, on any part of the body.

Definition: A skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage I pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions /sores are skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4.

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: All skin ulcers should be coded in this item. Record the number of ulcers at each stage on the resident's body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter a "9" in the appropriate box.

Clarifications:

CMS acknowledges that the National Pressure Ulcer Advisory Panel (NPUAP) has published guidelines for pressure ulcer stages and is considering changes to the existing MDS coding procedures for the future. For the present, staff should code the MDS using a reverse staging protocol. For the MDS assessment, code the ulcer in terms of what you see (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a stage 2 ulcer must be coded as a "2".

- A skin examination is necessary for problem identification and accurate coding of this item. Without a full body check, an ulcer can be missed. This examination must be performed by a clinician knowledgeable in the process of evaluating skin integrity. It does not necessarily have to be performed by the assessor completing the MDS form. Some facilities have found that it is more convenient for staff, as well as for residents, when the skin assessment is conducted during bathing or dressing activities.

- All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, not the status of such.

- Code ulcers that correspond to the definitions provided on the form and in this item, regardless of the cause of the ulcer. A Stage 2 ulcer is defined as "A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater". A blister in the incontinence brief area should be considered as a Stage 2 ulcer.

- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5, or SB-MDS Item 34 (Skin Treatments).

- If a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on his sacrum while being pulled up in bed), it should be coded as a Stage II ulcer.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Stage	Code
a. 1	2
b. 2	0
c. 3	1
d. 4	0

Example

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: Four of them are consistent with Stage 2 ulcer staging and one of them appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Item M1, Ulcers (due to any cause).

M1a Code "0" (no ulcers at Stage 1)
M1b Code "4" (4 ulcers at Stage 2)
M1c Code "1" (1 ulcer at Stage 3)
M1d Code "0" (no ulcers at Stage 4)

Item M2, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Item M4, Other Skin Problems or Lesions Present

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in M5 and M6 (Foot Problems and Care) as appropriate.

M2. Type of Ulcer (7-day look back) (*SB-MDS Item 32*)

F, MPAF, SB

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that were present in the last 7 days.

Definition: ▲ **a. Pressure Ulcer** - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

☆ **b. Stasis Ulcer** - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Clarifications: ◆ More definitive information concerning pressure ulcers is provided in the AHCPR Guidelines for pressure ulcers in adults:

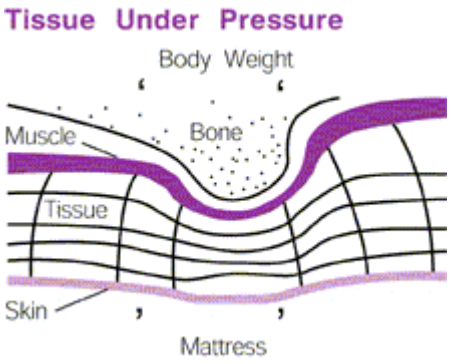
What are Pressure Ulcers?

www.ahrq.gov/consumer/bodysys/edbody6.htm

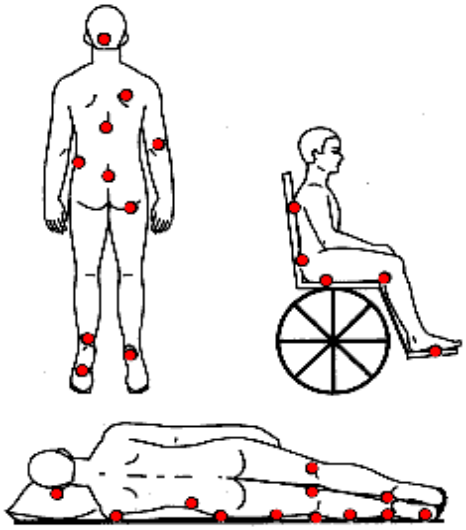
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

The full AHCRP guideline for clinicians can be found at **http://www.ahcpr.gov/clinic/cpgonline.htm**.

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band is a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

- If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. <u>If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer.</u> Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to

pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

Coding: Using the ulcer staging scale in Item M1, or SB-MDS Item 31, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1, or SB-MDS Item 31, may not necessarily be recorded in Item M2, or SB-MDS Item 32 (see last example below).

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

M1. Ulcer (due to any cause)	**Code (# at Stage)**
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0

M2. Type of Ulcer	**Code (highest stage)**
a. Pressure ulcer	2
b. Stasis ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

M1. Ulcer (due to any cause)	**Code (# at Stage)**
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0

M2. Type of Ulcer	**Code (highest stage)**
a. Pressure ulcer	0
b. Stasis ulcer	0

M4. Other Skin Problems or Lesions Present	Code
c. Open lesions other than pressure or stasis ulcers, rashes, cuts	√

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

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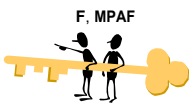
M3. History of Resolved/Cured Ulcers (90 days ago)

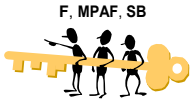


Intent: To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it is a risk factor for development of subsequent ulcers.

Process: Review clinical records, including the last Quarterly or Medicare PPS assessment

Coding: Code "**0**" for No or "**1**" for Yes.

M4. Other Skin Problems or Lesions Present (7-day look back) (*SB-MDS Item 33*)



Intent: To document the presence of skin problems other than ulcers, and conditions that are risk factors for more serious problems.

Definition:

☆ **a. Abrasions, Bruises** - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

▲ **b. Burns (Second or Third Degree)** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

▲ **c. Open Lesions/Sores Other Than Pressure or Stasis Ulcers, Rashes, Cuts (e.g. cancer lesions)** - A local loss of epidermis and variable levels of dermis and subcutaneous tissue. This open sore may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis.

☆ **d. Rashes** - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

☆ **e. Skin Desensitized to Pain or Pressure** - The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.

- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.

- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."

- Compare the sensations in symmetrical areas on both sides of the body.

- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.

- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

☆ **f. Skin Tears or Cuts (Other Than Surgery)** - Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shear, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneouse tissue in M4a.

▲ **g. Surgical Wounds** - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds.

h. ***NONE OF ABOVE (Not Used on the SB-MDS)***

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask nurse assistant. Review the resident's record.

Coding: Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should **not** be coded here. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE.*

Clarifications: ◆ It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

F, MPAF, SB

M5. Skin Treatments (7-day look back)

(*SB-MDS Item 33*)

Intent: To document any specific or generic skin treatments the resident has received in the past seven days.

Definition:

▲ **a. Pressure Relieving Device(s) for Chair** - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

▲ **b. Pressure Relieving Device(s) for Bed** - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

▲ **c. Turning/Repositioning Program** - Includes a continuous, consistent program for changing the resident's position and realigning the body.

▲ **d. Nutrition or Hydration Intervention to Manage Skin Problems** - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.

▲ **e. Ulcer Care** - Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

▲ **f. Surgical Wound Care** - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

▲ **g. Application of Dressings (With or Without Topical Medications) Other Than to Feet** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

▲ **h. Application of Ointments/Medications (Other Than to Feet)** - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

☆ **i. Other Preventative or Protective Skin Care (Other Than to Feet)** - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, sheepskin, padded, quilted).

j. ***NONE OF ABOVE (Not Used on the SB-MDS)***

Process: Review the resident's records. Ask the resident and nurse assistant.

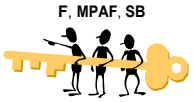
Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

Clarifications:

- Good clinical practice dictates that staff should document treatments listed in MDS Item M5 and SB-MDS Item 34, Skin Treatments (e.g., turning and repositioning program; application of ointments) and MDS Item M6 and SB-MDS Item 35, Foot Problems and Care (e.g., trimming of nails/calluses; application of dressings). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

- Dressings do not have to be applied daily in order to be coded on the MDS or SB-MDS. If any dressing, meeting the MDS and SB-MDS definitions provided for MDS Items M5e-h and SB-MDS Items 34a-h , was applied even once during the 7-day period, the assessor would check the appropriate MDS item.

M6. Foot Problems and Care (7-day look back) (*SB-MDS Item 35*)



Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition:

☆ **a. Resident Has One or More Foot Problems (e.g., Corns, Callouses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems** – includes ulcerated areas over plantar's warts on the foot.

▲ **b. Infection of the Foot** - Cellulitis, Purulent Drainage

▲ **c. Open Lesions On the Foot** - Includes cuts, ulcers, fissures.

☆ **d. Nails or Callouses Trimmed During the Last 90 Days** - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

☆ **e. Received Preventative or Protective Foot Care** - Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down,

sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

▲ **f. Application of Dressings (With or Without Topical Medications)** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. ***NONE OF ABOVE (Not Used on the SB-MDS)***

Process: Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

Clarification:

◆ For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6.

Discharges and Readmissions

5-26. For each of the 3 discharge codes, how should A8a and A8b be coded when the resident returns to the facility? How should AB1 (date of entry) be coded upon the return? What HIPPS codes should be used?

a. Reason for Discharge = 6, Return not Anticipated:

OBRA Assessments -If the resident returns, it is considered a new stay.

Date of Entry (MDS Item AB1): The Date of Admission changes to reflect the first day of the new stay, and a new initial admission assessment is required.

Medicare Assessments - The Medicare assessment schedule starts over with a 5-day Medicare assessment (A8b=1).

HIPPS Code - If the 5-day assessment is also the initial admission assessment, the HIPPS =11. If the 5-day PPS assessment is not the initial admission assessment, the HIPPS =01.

b. Reason for Discharge = 7, Return Anticipated:

OBRA Assessments -Complete a Reentry Tracking form, if appropriate. (See instructions for completing the Reentry Tracking form in the SOM). If the resident did not have a significant change, the original OBRA MDS schedule should be continued. If the resident has experienced a significant change in status, complete an SCSA upon the resident's return (A8a=3). Your next OBRA assessment will be due 92 days from the completion date of the SCSA.

Date of Entry (MDS Item AB1) -Retain the original date of admission in MDS Item AB1 and report the reentry date in MDS Item A4. The new start date for Medicare Part A coverage will be shown on the Part A bill the SNF sends to the Fiscal Intermediary.

Medicare Assessments -If the beneficiary was in a Part A stay prior to the hospital stay, complete a Readmission/Reentry

Assessment (MDS Item A8b=5). The 5-day Readmission/Reentry assessment restarts the Medicare Assessment schedule. This 5 day Medicare assessment can be combined with an OBRA SCSA (A8a=3 and A8b=5) or can be prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b-5).

If the beneficiary was NOT in a Part A stay prior to the hospital stay, complete a Medicare 5-day assessment (MDS Item A8b=1). Retain the original admission date (MDS Item AB1), and, for billing purposes, use the reentry date as Day 1 of the Medicare stay. The 5-day assessment starts the Medicare Assessment schedule, and can be combined with an OBRA SCSA (A8a=3 and A8b=1) or can be prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b=1).

HIPPS Code -If the 5-day Readmission/Reentry assessment is combined with an OBRA SCSA (A8a=3 and A8b=5), the HIPPS code = 35. If the 5-day Readmission/Reentry assessment is prepared strictly for Medicare payment purposes (MDS Item A8a=00 and A8b-5), the HIPPS code = 05.

c. **Reason for Discharge 8: Discharged Prior to Initial Admission Assessment**

OBRA Assessments - This code (MDS Item A8a=8) is used whenever the resident is discharged prior to completing the initial admission assessment. This code is used even if a Medicare 5-day assessment has been completed. This code is also used regardless of whether you expect the resident to return. The OBRA initial admission assessment must be completed within 14 days of the reentry date.

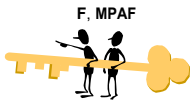
Date of Entry (MDS Item AB1) -Retain the original date of entry. Enter the readmission/return date in MDS Item A4.

NOTE: The March 2001 Q & A’s say that a reentry tracking record is not needed after a reason for discharge = 8.

Medicare Assessments -Generally, facilities complete Medicare assessments in order to establish a RUG-III group for payment. If the beneficiary had been in a Part A stay prior to the hospitalization, complete a Medicare Readmission/Reentry assessment. If the beneficiary was not in a Part A stay prior to the hospital stay, but returns with Part A eligibility, complete a 5-day Medicare Assessment, A8b = 1.

HIPPS Codes - If the beneficiary was in a Part A stay prior to the hospitalization, complete a Medicare Readmission/Reentry assessment (A8b=05). The HIPPS code will vary depending upon whether the 5-day assessment is combined with the initial admission. If A8a=1 and A8b = 5, **the HIPPS code = 11**. If A8a=00 and A8b=1, the HIPPS code = 05.

P4. Physical Restraints (7-day look back)



Intent: To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

Definition: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

a. Full Bed Rails - Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). Include in this category veil screens (used in pediatric units).

b. Other Types of Bed Rails Used - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above "full bed rail" category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c. Trunk Restraint - Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d. Limb Restraint - Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e. Chair Prevents Rising - Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g., bean bag chair). Include in this category enclosed framed wheeled walkers with or without a posterior seat.

Process: Check the resident's clinical records and restraint flow sheets. Consult nursing staff. Observe the resident. The assessor should not focus on the

intent or reason behind the use of the device, but on the effect the device has on the resident. Does the device, material, or equipment meet the definition of a physical restraint? If so, code the item in the appropriate category.

Coding: For each device type, enter:

0. Not used in last 7 days

1. Used, but used less than daily in last 7 days

2. Used on a daily basis in last 7 days

Because the coding categories are limited, we have given some direction on which category to code particular devices. While the device may not be completely representative of the category description, follow the coding instruction as given. There may be devices that we have not giving coding instruction and that there is not a category that is representative of the device. For those devices, do not code at this time, but note that in subsequent versions of the MDS, CMS will include an "other" category that would be an appropriate place to code these devices.

Exclude from this P4 section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck or back braces, and bandages that are serving in their usual capacity to meet medical need.

Clarifications:

- Cognitively impaired residents are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases the risk of using the device may be greater than the risk of not using the device.

- As will be set forth in the guidance to surveyors, the Merry Walker® and similar devices should not be categorically classified as a restraint. The following coding information provides further detailed guidance on how to code utilization of the device that might for a particular resident be considered a restraint. If these devices assist ambulation for a particular resident, they should be coded as a cane/walker/crutch, whether or not they are coded as a restraint.

  (1) **Coding When Not a Restraint**

  If a resident is able to easily open the front gate and exit the device, the device should **not** be coded as a restraint for this particular resident. It would be coded at Item G5a as a Cane/walker/crutch.

  (2) **Coding When a Restraint**

  (a) Only if the device has the effect of restricting the resident's freedom of movement, should the device be considered a restraint. If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be coded as a restraint in section P4e of the MDS.

(b) The current version of the MDS (Version 2.0) does not contain a category for a restraint in which this device obviously falls. We understand that these devices do not prevent a resident from standing. Nevertheless, until CMS releases the next version of the MDS, when the device restricts freedom of movement, code the device at item P4e "chair prevents rising" with either a "1" Used less than daily, or a "2" Used daily. In subsequent versions of the MDS, CMS will include an "other" category, which would be an appropriate place to code this type of device.

(c) Coding the device at section P4e does not preclude the facility from also coding the device at G5a "Cane/walker/crutch" if the resident used the device to walk during the last 7 days.

Request for Restraints:

While a resident, family member, legal representative or surrogate may request that a restraint be used, the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. According to the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be restrained for discipline or convenience. Prior to employing any restraint, the nursing facility must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The guidelines in the State Operations Manual (SOM) State, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or convenience or when the restraint is not necessary to treat the resident's medical symptoms." That is, the facility may not use restraints in violation of regulation solely based on a legal surrogate or a representative's request or approval. The SOM goes on to State, "While Federal regulations affirm a resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatments that the facility deems inappropriate." Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions.

Are Restraints Prohibited?

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing facilities, except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation States, "The resident has the right to be free from any

physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Prior to using any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. The assessment should take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.

Bed Rails Used as Positioning Devices:

In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. If the side rail has the effect of restraining the resident, the facility is responsible to assess the appropriateness of that restraint. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The assessment should take into consideration the risks of using the device and the feasibility of employing an alternate, less restrictive means to accomplish the desired outcome. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. While bed rails may serve more than one function, the assessor should code P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at MDS Item P4 (a or b, as appropriate) *and* at MDS Item G6b (Bedrails used for mobility or transfer).

Devices Used with Immobile Residents:

Side Rails - Physical restraints are defined as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, staff needs to determine if there is any appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body toward the edge of the bed. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a restraint, they may affect the resident's quality of life.

Geriatric Chairs - For a resident who has no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint, and should not be coded at Item P4e.